STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185400	A. BUILDING _____ B. WING _____	10/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE PLACE	506 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey and abbreviated surveys (KY #15251 & KY #15413) were conducted on 10/12/10 through 10/15/10 to determine the facility's compliance with Federal certification requirements. The facility was found not to meet Federal requirements for recertification with the highest S & S being a "D". KY #15251 & KY #15413 were unsubstantiated with no deficiencies cited.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure services were provided in accordance with care plan interventions for two residents (#1 and #4), in the selected sample of 15. The facility failed to ensure Resident #1 was turned and repositioned every hour and hand mitts were removed every two hours for 15 minutes. The facility failed to ensure Resident #4 was assisted by two staff during transfers. Findings include: A review of the facility's policy related to the use of care plans, which was undated, revealed "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have the responsibility for providing care or services to the resident. Nurse Aide Care Plans are to be available at all times.	F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN On 11/1/2010, the medical records, care plans and nurse's aides care plans of residents #1 and #4 were reviewed and updated by the facility DON. The audit revealed the following immediate interventions implemented post incident: • On 10/14/2010, Resident #1 was addressed by a licensed nurse and it was determined that resident had incurred no decline in status due to not being turned and repositioned every hour and not being released from hand mitt restraints for fifteen minutes every two hours. • On 8/10/2010, Resident #4 was assessed by a licensed nurse and determined to have incurred no decline in status due to being transferred with one staff member. On 11/10/2010, an audit was completed, by the MDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen C Evans — TITLE: Administrator — (X6) DATE: 11/19/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185400	A. BUILDING _____ B. WING _____	10/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE PLACE	506 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 NACP are to include details regarding care provided by the nurse aide to include specific ADL instructions." 1. A record review revealed Resident #1 was admitted to the facility with diagnoses to include Altered Mental Status, Dementia and Chest Mass. A review of the resident's care plan, dated October 2010, revealed Interventions included repositioning of the resident every hour from side to side with assistance of two staff and a mitten/glove was to be worn on both of the resident's hands, to protect an external chest mass. The mittens/gloves were to be checked every 30 minutes and released every two hours for 15 minutes. Observations on 10/14/10 at 10:00 AM, at 11:00 AM, at 11:45 AM, at 12:00 PM, at 1:15 PM and at 2:40 PM revealed Resident #1 was lying in bed on his/her left side with a hand mitt on each hand. An interview with Licensed Practical Nurse (LPN) #2, on 10/14/10 at 2:50 PM, revealed she was working in the position of a Certified Nurse Aide that shift and was assigned responsibility for Resident #1's care needs. However, LPN #2 was not knowledgeable regarding how often the mittens/gloves were to be removed. She stated she removed them once during the shift, while bathing the resident. LPN #2 could not provide a reason for Resident #1 remaining on his/her left side, from 10:00 AM through 2:40 PM on 10/14/10. An interview with LPN #1, on 10/14/10 at 3:15 PM, revealed Resident #1 was totally dependent	F 282	Coordinator and House Supervisor, of all physician orders, comprehensive care plans, and nurse's aide care plans. Residents on one hour turns, orders for restraints, and assistance with ADLs were reviewed to ensure all current physician orders are included in the comprehensive care plan and on the Nurse's Aide Care Plan. On 11/11/2010, facility nursing staff were in-serviced, by the DON, on Restraints Policy, Turing and Repositioning, ADL assistance, Using Care Plan Policy and assignments of responsible staff to conduct care according to care plan. (Attachment #1) Focus Review "NACP" was completed 11/2/2010 and will be completed monthly for three consecutive months and then as per quarterly Continuing Quality Improvement schedule (Attachment #2) to ensure services provided are in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185400	A. BUILDING _____ B. WING _____	10/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE PLACE	506 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 for repositioning. She stated she was responsible for performing compliance rounds, but had only been in Resident #1's room one time, on 10/14/10. Additionally, LPN #1 stated she "didn't know who actually was responsible to ensure proper turning and repositioning". 2. A record review revealed Resident #4 was admitted to the facility with diagnoses to include Seizure Disorder and Brain Atrophy. A review of the Resident's current care plan, revealed Resident #4 required total assistance of two staff members with bed mobility and transfers. A review of the post-fall assessment, dated 08/10/10 at 9:15 AM, revealed Resident #4 was assisted from the wheelchair to bed, by only staff member and sustained a fall. A revision was made on the resident's care plan to "Reinforce use of 2 person assist for transfers". An interview with CNA #1, on 10/15/10 at 10:15 AM, revealed she had transferred Resident #4 without the assistance of a second staff member, on 08/10/10, because "I couldn't find anyone; they were all taking a smoke break". An interview with the Director of Nursing, on 10/15/10 at 1:15 PM, revealed CNAs were to follow the care plan. The DON stated problems had been identified which included poor communication between staff, poor follow-up and a lot of change over of staff.	F 282	accordance with each resident's written plan of care. 483.25(M)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE On 10/12/2010, Medication Error Form and Unusual Occurrence Form were completed on Resident #13. On 11/1/2010, upon review of the indicated the Administrator noted: • Doctor and Family were notified of medication errors. • After 72 hour monitoring was completed, there had been no signs and symptoms of adverse reaction to the medication errors. On 11/09/2010, nursing staff assignments were reviewed and adjusted to ensure adequate time is allowed for compliant medication passes. An action plan was developed 11/9/2010	Completion Date: 11/15/2010
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185400	A. BUILDING _____ B. WING _____	10/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 332	Continued From page 3 medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure that it remained free of medication error rates of five percent or greater. Forty five opportunities were observed with three (3) medication errors identified, which affected one resident (#13), in the selected sample of 15. The facility had a medication error rate of 6%. Findings include: A review of the physician's order, dated October 2010, revealed Coreg 6.25 milligrams (mg), Mobic 7/50 mg, and Mucinex ER were to be administered for Resident #13 twice daily. A review of the Medication Administration Record revealed the medications were scheduled for administration at 9:00 AM. An observation during the medication pass, on 10/12/10 at 11:00 AM, revealed Resident #13 was administered the Coreg 6.25 milligrams (mg) and Mobic 7.50 mg. at 11:00 AM. Mucinex ER was not administered as ordered. An interview with Certified Medication Technician (CMT) #1, on 10/14/10 at 10:00 AM, revealed the medications had been administered late frequently, due to a big turn over in staffing. CMT #1 stated she was late with the administration of the medications on 10/14/10, because of short staffing in the dining room. Additionally, CMT #1 stated she did not realize she had omitted the Mucinex ER and she did not	F 332	nd then reviewed 11/15/2010. On 11/15/2010, a second Certified Medication Technician was added to staffing - seven days weekly. On 11/3/2010, Pharmacy Nurse Consultant 1) conducted med pass observations on DON and ADON and 2) ensured DON and ADON competency of Med Pass system and Med Pass Observations. (Attachment #3) By 11/10/2010, Medication Pass reviews will be conducted on facility Certified Medication Technicians and Licensed Nursing staff to ensure competency and ensure medication error rate is not above 5%. An in-service will be completed on 11/11/2010 including Administration of Medication Policy, Unusual Occurrence Policy and Med Error Reporting Policy. On 11/2/2010, CQI N-16 "Review of Med Pass" was completed 11/2/2010 and will be completed monthly for three	

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	185400	A. BUILDING _____ B. WING _____	10/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE PLACE	506 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220

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F 332	Continued From page 4 notify the nurse the medications were administered late. An interview with the Director of Nursing, on 10/14/10 at 2:00 PM, revealed medication was to be administered within an hour before or an hour after the prescribed time (9:00 AM) and CMT #1 should have made the nurse aware.	F 332	consecutive months and then as per quarterly Continuing Quality Improvement schedule (Attachment #4) to ensure facility is free of medication error rates of five percent or greater.	Completion Date: 11/15/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185400	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTHSTONE PLACE	506 ALLENSVILLE ROAD, P.O. BOX 427 ELKTON, KY 42220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 10/12/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Complete
In-Service Training Report

Facility: Hearthstone Place **Department:** Nursing
Date: 11/11/2010 **Time:** 1300

Meeting Area: Classroom

Employee Group(s) Present: Facility Staff

Subjects Covered: 2010 Annual OIG Survey Plan of Correction Education NF
Facility Nursing Staff
I) Restraint Policy - see attached policy
II) Turn and Reposition
III) Using Care Plan Policy - see attached policy
IV) CNA is responsible for CNA Care Plan
Charge Nurse is responsible for Comprehensive Care Plan nursing interventions not included on CNA Care Plan
Policies attached
V) Questions and Answers
Certified Medication Technicians and Licensed Staff
VI) Administration of Medication Policy - see attached policy
VII) Unusual Occurrence Policy - see attached policy
VIII) Med Error Reporting Policy - see attached policy

Conducted by: _____

Title: _____

Signature: _____

Attachment #1

NACP FOCUS REVIEW

Date: _____

KEY POINTS OF REVIEW

A.

1. Does each resident have a Nurse Aid Care Plan?
2. Review 10% of current census for Resident NACPs and observe if the C.N.A staff follows the directions.
3. Review the NACP for accurate Shower schedule and observe for C.N.A compliance with these directions.
4. Review the NACP for accurate B&B directions and observe for C.N.A compliance with these directions.
5. Review the NACP for accurate Restorative Nursing directions and observe for C.N.A compliance with these directions.
6. Review the NACP for accurate Dining instructions and observe for C.N.A compliance with these directions.
7. Review the NACP for accurate Skin Care instructions (i.e., T/P instructions, specialty beds, geri-sleeves or geri-leg protectors, skin barrier cream, etc.). Observe for C.N.A compliance with these directions.
8. Review the NACP for accurate ADL instructions and observe the C.N.A compliance with these directions.
9. Review the NACP for any other special instructions and observe the C.N.A compliance with these directions.
10. Review the NACP for any instructions related to assistive devices and observe for C.N.A compliance with these directions.
11. Review the NACP for Oral Care instructions and observe the C.N.A compliance with these directions.
12. Review the NACP for Restraint use instructions and observe for C.N.A compliance with these directions.

B. Summary of Deficient Area:

C. Isolated or System Failure (Action Plan Required)

D. Immediate Action Initiated:

E. Team Facilitator Signature: _____

Attachment #2

QA CONFIDENTIAL INFORMATION

Quality Indicator: Review of Medication Pass **N-16**
Threshold: 98%

Directions: A member of the CQI committee will observe and monitor medication pass in keeping with the criteria listed below. It is also suggested that different medication pass times be used. Enter a "Y" for yes or an "N" for no. A no response may indicate a potential problem.

	Criteria / Question	Resident				
	X = Yes O = No N/A = Not Applicable	1	2	3	4	5
1	Medication are given by a qualified individual.					
2	Medications are prepared immediately prior to giving.					
3	Medication is given by the same person who prepared them.					
4	The resident is positively identified prior to being given medication. Resident is properly positioned when administering medication.					
5	Medication is given after special procedures are followed (pulse, B/P, etc.) if appropriate.					
6	Medication given is consistent with the physician's order.					
7	Physician orders are clear and easy to understand.					
8	Physician orders include the following information;					
	Medication Name					
	Specific dosage					
	Specific route					
	Specific administration time (daily, BID, TID, q 6 hrs, etc.)					
9	Is medication cart locked when med nurse is not present.					
10	Medication given within @ least 60 minutes before/after scheduled times.					
11	Liquid meds are shaken well and poured at eye level or measured with a syringe for odd doses.					
12	Resident is not left until all meds are taken.					
13	Meds are charted at the time given.					
14	Meds are crushed following protocol.					
15	Infection control practices are followed.					
16	There is follow up documentation for PRN meds.					

Attachment #4a

17	Fluid and food items are covered and dated.					
18	AC, PC, with meals, with food orders administered correctly.					
19	Medications are not left on top of cart or at resident's bedside.					
20	Refused / Withheld medications are properly noted.					
21	Opthalmics administered properly.					
22	Inhalers properly administered/stored; mouthpieces cleaned.					
23	Injections properly prepared, administered, and documented.					
24	Transdermal patches rotated, removed, dated and initialed properly.					
25	Medication via feeding tube is documented properly at time of administration.					
26	Flushes are administered per MD orders before and after medication administration.					
27	Tube placement is verified prior to medication administration via tube.					
28	Controlled drugs documented properly at time of administration.					
29	Medication administered per manufacture's specification.					
30	Medication administered per facility policies and procedures.					

Percentage of Compliance = $\frac{\text{\# Yes responses}}{\text{total \# of responses}} \times 100$ **% Compliance** _____

Threshold met: **YES NO** Plan of correction implemented: **YES NO**

Date completed:_____ By:_____

Revised 10/18/10

Attachment #46